Washington State
Medical Assistance Administration

2001 *Healthy Options* Focused Review
Early and Periodic Screening, Diagnosis, and Treatment

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Contents

Executive Summary

This report presents the results of a retrospective performance review of well-child care (WCC) provided by Washington Medical Assistance Administration's (MAA's) managed care organizations (MCOs) and fee-for-service (FFS) providers. This 2001 report covers WCC delivered from October 1, 1998 through December 31, 2000.

The review assesses performance based on the frequency and completeness of WCC visits compared with age-specific Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. The review also measures the rate at which clients received appropriate follow-up when health problems were identified during a WCC visit or other encounter, and notes whether the provider used structured WCC examination forms to document the visit.

Review findings form the basis of quality improvement strategies. For example, since determining that providers' use of structured WCC examination forms correlates with increases in qualifying WCC visit rates, MAA has promoted clinic use of these age-appropriate forms.

A quality improvement strategy employed this year involved providing individual clinics with summary reports of their own performance rates compared with benchmarks based on top-performing peers. These Achievable Benchmarks of Care (ABC™) allow clinics to self-evaluate and set improvement goals. Eighty clinics received summary ABC reports along with relevant educational information. The effect of providing this direct feedback to clinics will be included in the 2002 analysis.

The procedure for conducting the reviews in 2001 was as follows: Medical records were randomly selected from enrollment data provided by MAA. Sample sizes for individual MCOs and FFS providers as a group were determined based on a 90 percent confidence level with a 10 percent margin of error. About half the medical records were mailed in for review and half were reviewed on site.

The results indicate that rates of reported WCC visits increased over last year, although rates of qualifying WCC visits—visits that meet *all* EPSDT requirements—lagged considerably behind those of reported visits. Anecdotal evidence suggests the lag might be due, in part, to providers' not understanding all the EPSDT requirements for a qualifying WCC visit. In addition, some required elements of a WCC examination may have been addressed by the provider, but not documented in the medical record.

This year, as in years past, the percentage of children and adolescents who received WCC visits is lower than that of infants, confirming a need to find better ways to reach children and adolescents needing WCC visits.

Introduction

Since 1994, Washington Medical Assistance Administration (MAA) has reviewed the performance of healthcare providers in meeting Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)[1] requirements for well-child care (WCC) delivered to persons receiving Medicaid. This 2001 report presents the results of a retrospective performance review of care provided by managed care organization (MCO) and fee-for-service (FFS) providers from October 1, 1998 through December 31, 2000.

The review analyzed data abstracted from medical records of clients served by 135 FFS providers and 9 participating MCOs. Approximately half of the records were mailed in for review and the other half were reviewed on site. All the records were reviewed for documentation of a WCC visit, other encounter visits, and visit follow-up. The use of structured WCC forms was also noted.

Purpose of the annual review

The annual review assesses rates of qualifying WCC visits by MCO and FFS providers. A qualifying WCC visit meets EPSDT requirements for frequency and completeness. MAA uses this annual assessment to monitor performance progress, identify areas that need improvement, and develop strategies to support improvement efforts.

New approaches to improvement

A new approach to improving performance involved providing feedback to selected clinics that had treated *Healthy Options*[2] clients during the review period. The feedback consisted of clinic-specific summaries of WCC visits for each age group compared with an Achievable Benchmark of Care (ABC™). ABC is a benchmarking technique that uses the actual performance of Washington peers to provide a community-based measure against which providers may evaluate their own performance and set improvement goals. (See Methods, page 9).

Along with the performance feedback, clinics received educational materials and tools that would help their improvement efforts. The materials provided were based on review results and included a table of EPSDT age-appropriate frequency and content requirements for qualifying WCC visits, a summary of areas that needed improvement with a list of recommended actions, and an example of a structured WCC examination form. Previous reviews have shown a strong correlation between use of structured forms and high rates of qualifying WCC visits. Some clinics also received on-site training and additional quality-improvement assistance. The effect of these interventions will be part of the 2002 review.

[1] Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated program designed to ensure that children under 21 whose healthcare is paid by Medicaid receive comprehensive care. Individual states must meet broad program requirements, but each state sets its own requirements within the federal parameters. Washington's EPSDT requirements are based on a combination of recommendations of the American Academy of Pediatrics and MAA Policies and Procedures.

[2] *Healthy Options* is MAA's program for providing healthcare through participating MCOs.

Results

This report presents the following results:

- the percentage of *reported* WCC visits in each age group—all visits identified in the medical record as a WCC, whether or not they met all EPSDT requirements
- the percentage of *qualifying* WCC visits—the percent of reported visits that met EPSDT requirements for frequency and completeness
- the ABC for reported and qualifying visits, by age group
- the rate of structured tool use among providers
- the percentage of clients who had no medical record available for review (those clients whose medical records could either not be located or who had no visits during the review period)
- the percentage of clients who received appropriate follow-up when problems were identified during a WCC or other medical encounter

Report organization

The report is organized as follows:

- The Background section describes the eligible population and EPSDT requirements, presents summaries of past reviews, and explains the rationale for elements new to this review.
- The Methods section provides a list of participating MCOs, the sample selection and review processes, the methods of analysis, and information about the ABC methodology.
- The Results and Discussion sections present aggregate, statewide performance rates for WCC visits by age group for clients who received care through an MCO and those who received their care on a FFS basis. In addition, the performance rates of the MCOs are compared with those of FFS providers and with an ABC.
- The Conclusions section summarizes the meaning of the results.
- The Recommendations section provides concrete suggestions for improving future rates.

Children who have no health insurance compared with children who have health insurance are

- *eight times more likely to lack a regular source of care*
- *six times more likely to go without needed medical care*
- *five times more likely to use the emergency room as their primary source of care*

1999 study by the American College of Physicians—American Society of Internal Medicine

Background

Eligibility

MAA provided MCO enrollment data and FFS claims data for Washington clients who were aged birth through 20 years, who had their healthcare paid by Medicaid in 2000, and who met the enrollment and age requirements for this review. (Enrollment and age requirements for this review are explained in the Methods section, page 6.) The total eligible population included 75,409 individuals.

EPSDT requirements

Tables 1 and 2 summarize Washington's EPSDT requirements that were in place from 1998 through 2000, the time frame of this review. Table 1 identifies the clinical areas and the elements within those areas that must be addressed at each WCC visit for the visit to be counted as a *qualifying* WCC visit. Table 2 shows the EPSDT frequency requirements.

Table 1. EPSDT required clinical areas and associated elements (visit must include the minimum number of elements).

Clinical area	Infants	Children	Adolescents
Physical exam and health history	*All* elements required History Physical Height Weight	*All* elements required History Physical Height Weight	*All* elements required History Physical Height Weight
Developmental assessment	*At least* one element Gross motor Fine motor Social/emotional Nutritional	*At least* one element Gross motor Fine motor Social/emotional Nutritional Communication Self-help skills Cognitive skills Regular physical activity	*At least* one element Social/emotional Nutritional Regular physical activity
Mental health assessment	Element *must* be addressed Mental health	Element *must* be addressed Mental health	*At least* one element Mental health Substance abuse
Health education/ anticipatory guidance	*At least* one element Injury prevention Passive smoking	*At least* one element Injury prevention Passive smoking	*At least* one element Injury prevention STD prevention Tobacco use

Table 2. Required visit frequency (year 2000 EPSDT requirements)*

Age group	Visit frequency	Expected visits during evaluation period	Required clinical areas (all four areas at each visit)
Infants (birth to 15 months)	At about 2, 4, 6, 9, 12, and 15 months	6	• Physical exam and health history • Developmental assessment • Mental health assessment • Health education/anticipatory guidance
Children (3 to 6 years)	Yearly	1	
Adolescents (12 through 20 years)	Every two years	1	

*The age ranges and required frequencies may vary slightly from year to year. MAA determines the specific EPSDT requirements based on recommendations made by the American Academy of Pediatrics and MAA Policies and Procedures.

Previous reviews

Previous reviews have included not only performance rates in reported and qualifying WCC visits, but also completion rates for individual elements within the required clinical areas. Improvement efforts were directed toward improving the rates for individual elements, under the assumption that the rates for qualifying WCC visits would improve correspondingly. However, even when rates for individual elements and reported WCC visits increased, qualifying WCC visit rates remained relatively flat.

These results suggested that quality improvement efforts should emphasize the importance of completing *all four required clinical areas* at every WCC visit, rather than focus on increasing the rates of individual elements within the clinical areas. The performance feedback reports stressed this point.

One of the more effective ways to improve the completion rate is to increase the use of age-appropriate, standardized WCC examination forms. In 1998, reviews began to note and report on structured WCC form use.

New to this review

Strategies for improving WCC visit rates initiated this year focused on

- educating providers in the EPSDT requirements
- providing feedback to clinics to promote self-evaluation and set goals for internal improvement efforts
- providing specific tools to support meeting EPSDT requirements

Feedback and self-evaluation tools included

- easy, concise reference on EPSDT requirements for a qualifying WCC visit
- short, graphical performance reports for individual clinics reviewed on site in 2000 and 2001
- the use of benchmarking—specifically ABC—to provide a comparison to a Washington State community-based benchmark[3]

[3] For a sample of an ABC feedback report, contact Anita Bobinet, PhD, EPSDT Project Coordinator, OMPRO, 503-279-0100.

Methods

Sample selection

MAA provided MCO enrollment and FFS eligibility data on MAA clients who met the following criteria:

- continuously enrolled for 13 months[4] (allowing for one 30-day break in enrollment) in a participating MCO health plan or eligible for FFS
- within the following age ranges (as set by MAA) between January 1 and December 31, 2000
  Infants: birth to 15 months of age
  Children: 3 through 5 years of age
  Adolescents: 12 through 20 years of age

The total eligible population consisted of 75,409 clients: 8,312 infants; 27,506 children; and 39,591 adolescents.

Sample sizes were determined for each MCO and for the FFS provider group based on a 90 percent confidence level with a 10 percent margin of error.

Client names were randomly selected from MCO records or FFS claims data, and their medical records were requested from the appropriate provider. Just over half of the records were mailed in for review; the remainder were reviewed at clinic or provider offices. In total, 2,647 records were requested: 2,377 from the 9 MCOs and 270 from FFS providers.

The nine participating MCOs are listed below. The 135 FFS providers were evaluated as a single group. Table 3, page 7, shows the distribution of the sample across the MCOs and the group of FFS providers.

Participating MCOs[5]

Aetna US Health Care of Washington	AUSH
Community Health Plan of Washington	CHPW
Columbia United Providers	CUP
Group Health Cooperative	GHC
Kaiser Foundation Health Plan of the Northwest	KFHP
Molina Healthcare of Washington, Inc.	MHCW
Northwest Washington Medical Bureau	NWMB
Premera Blue Cross	PBC
Regence BlueShield	RBS
Fee-for-Service Providers	FFS

[4] The enrollment requirement for 2001 review was changed from 12 to 13 months to allow redistribution of enrollees after some MCOs opted out of the *Healthy Options* program.

[5] Most of the MCOs participated in both the *Healthy Options* and the Basic Health Plan-Plus (BHP+) programs. During this review period, Kaiser Foundation and Regence BlueShield participated in the BHP+ program only.

Table 3. Distribution of the sample across participating MCOs and FFS providers.

MCO	Infants	Children	Adolescents	All ages
AUSH	85	92	94	271
CHPW	92	95	95	282
CUP	82	91	92	265
GHC	87	93	94	274
KFHP	70	73	80	223
MHCW	91	94	94	279
NWMB	82	88	90	260
PBC	88	93	94	275
RBS	70	87	91	248
FFS	81	94	95	270

The core sample includes only those who received services through an MCO, excluding the FFS clients. A profile of the core sample by age and ethnicity is shown in Table 4.

A profile for the FFS sample is shown in Table 5, page 8. A profile of the total sample by age and gender is shown in Table 6, page 8.

Table 4. Number in core sample, by age and ethnicity

				All ages	
	Infants	Children	Adolescents	No.	%
Non-Hispanic Caucasian	419	525	549	1493	63
African-American	37	54	40	131	6
Asian	28	58	71	157	7
Native American	6	1	6	13	1
Hispanic	124	106	63	293	12
Other	57	46	71	174	7
Unknown	76	16	24	116	4
Total	747	806	824	2377	100

Table 5. Number in FFS sample, by age and ethnicity

				All ages	
	Infants	Children	Adolescents	No.	%
Non-Hispanic Caucasian	50	38	46	134	50
African-American	4	7	3	14	5
Asian	1	3	3	7	3
Native American	1	2	3	6	2
Hispanic	10	32	30	72	27
Other	8	10	8	26	10
Unknown	7	2	2	11	3
Total	81	94	95	270	100

Table 6. Total sample, by age and gender

	Infants		Children		Adolescents	
	No.	%	No.	%	No.	%
Male	407	49	476	53	485	53
Female	421	51	424	47	434	47

Performance rate calculations

Expected WCC visits: The number of *expected* WCC visits is the denominator for calculating both *reported* and *qualifying* WCC performance rates. The expected number of WCC visits is the total number of age-appropriate visits within the time frame specified by the EPSDT requirements. In other words, infants are expected to have six visits during the review period; children and adolescents are expected to have one visit during the review period. Consequently, the expected number of visits for infants equals the number of infants multiplied by six, and the expected number of visits for children and adolescents equals the number of individuals in the review sample.

Reported WCC visits: All visits that were documented as a WCC visit in the medical record were considered *reported* WCC visits, which were then reviewed for completeness. The *reported* WCC visit rate is the number of *reported* WCC visits divided by the number of *expected* WCC visits.

Qualifying WCC visits: *Reported* WCC visits that had medical records documenting the minimum number of required elements in all four of the required clinical areas (see Table 1, page 4) were counted as *qualifying* WCC visits. The *qualifying* WCC visit rate is the number of *qualifying* WCC visits divided by the number of *expected* WCC visits.

Review process

MAA provided enrollment and claims data according to the following HEDIS®[6] enrollment requirements and MAA age ranges.

Infants (birth to 15 months)
Clients who turn 15 months of age between January 1 and December 31 of each preceding year. According to HEDIS specifications, the client must have been continuously enrolled in a single health plan from 31 days of age, allowing for one 30-day break in enrollment. The entire record from birth to 15 months of age is reviewed to collect data for all of the WCC visits received by this age group.

Children (3 to 6 years)
Clients who are at least 3 and not yet 6 years of age between January 1 and December 31 of each preceding year. They must have been continuously enrolled in a single plan for all of 2000, allowing for one 30-day break in service. All records of encounter and WCC visits were reviewed for the calendar year 2000.

Adolescents (12 through 20 years)
Clients who are at least 12 but not yet 21 years of age between January 1 and December 31 of each preceding year. They must have been continuously enrolled in a single plan for all of 2000, allowing for one 30-day break in service. Per current MAA Policies and Procedures, records of encounter and WCC visits of adolescents are reviewed for two calendar years (1999 and 2000).

Inter-rater reliability and data accuracy

Inter-rater reliability was assessed midway through the review process. Inter-rater reliability is measured by the kappa coefficient of agreement among reviewers. The kappa coefficient for this review ranged from 0.88 to 0.93, indicating a high degree of reliability. The accuracy of the data is measured by a kappa coefficient of agreement with a "gold standard." Agreement in this review ranged from 0.90 to 0.97, indicating "almost perfect" agreement.

ABC methodology

MCO and FFS performance rates for each age group are compared with Achievable Benchmarks of Care (ABC™). These benchmarks are calculated from the best rates among the actual performance of providers in this study. Calculating the benchmarks involves

1. ranking providers by rate of indicator performance
2. selecting top-performing providers in descending order to include 10 percent of the total number of patients
3. pooling, then averaging the performance data from the selected physicians to define the benchmark

The ABC methodology was developed for quality improvement applications in medical settings by the Center for Outcomes and Effectiveness Research and Education at the University of Alabama in Birmingham.[7]

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

[7] Weissman NW, Allison JJ, Keife CI, et al. Achievable benchmarks of care: the ABC™s of benchmarking. *J Eval Clin Pract* 1999;5(3):269–81.

Results

This section presents reported and qualifying WCC visit rates for infants, children, and adolescents. The rates are first presented by age group and health plan, followed by aggregate, statewide results for all age groups. In addition to performance rates for WCC visits, aggregate statewide results also include rates of structured WCC form use, year-to-year comparisons, frequency of other medical encounters, and rates for following up after WCC or other encounter visits.

Performance rates for infant WCC visits

Figures 1 and 2 show the reported and qualifying WCC visit rates for the FFS provider group and each MCO compared with the ABC. The denominator for both reported and qualifying visits equals the number of infants' records in each sample multiplied by six—the expected number of visits in the review period.

Figure 1. Reported WCC visit rates for infants

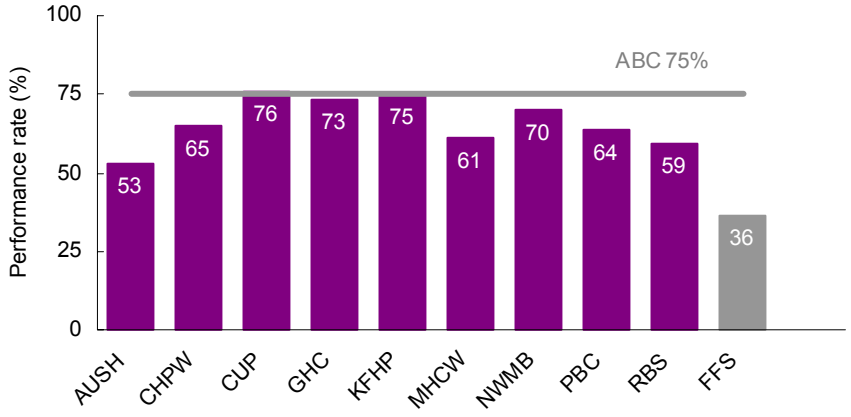


Figure 2. Qualifying WCC visit rates for infants

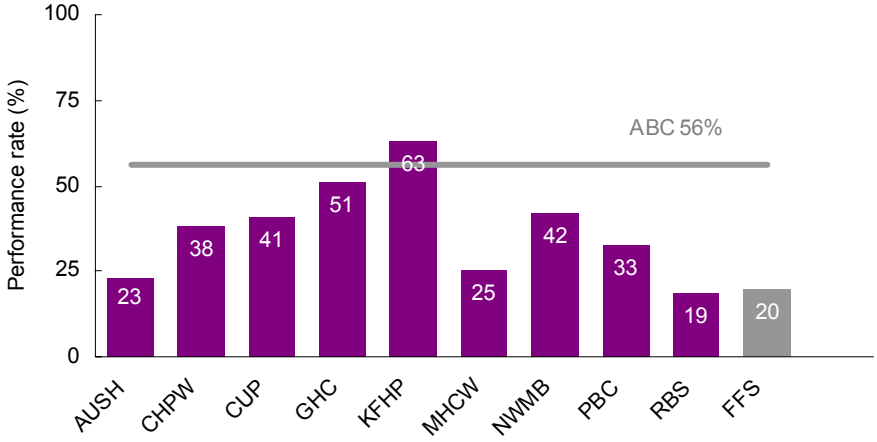
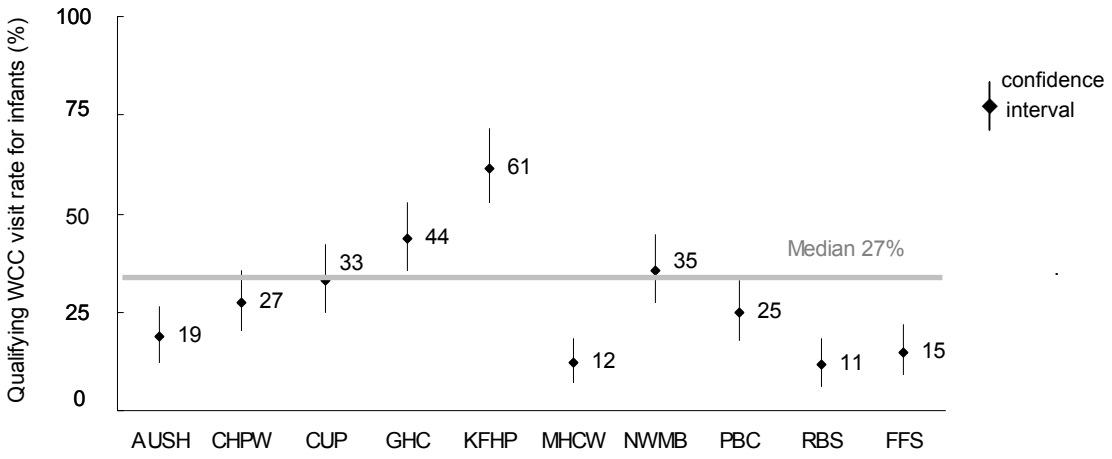


Figure 3 shows MCO and FFS *qualifying* visit rates with associated confidence intervals (shown as the vertical line), for infants who received *a minimum of four* WCC visits within the review time frame. Unlike Figures 1 and 2, the unit of measure is the *individual*, not the *visit*. The denominator is the total number of *individual infants* in each sample. The numerator is the number of individual infants who received *at least four qualifying* WCC visits from an MCO or FFS provider during the review period. Calculations are based on a 90 percent confidence level with a 10 percent margin of error.

Figure 3. MCO and FFS performance rates for infants receiving at least four qualifying WCC visits



Performance rate for child WCC visits

Children are expected to have one WCC visit every year. The denominator—the expected number of visits—equals the number of children in each sample.

Figure 4. Reported WCC visit rates for children

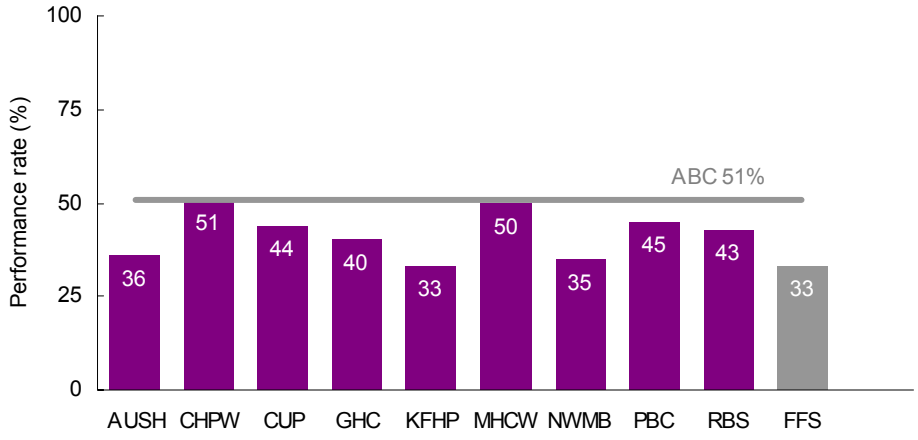


Figure 5. Qualifying WCC visit rates for children

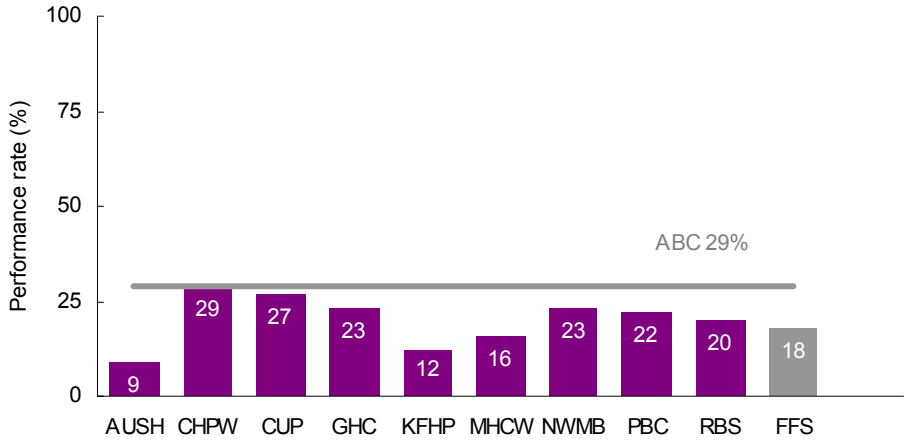
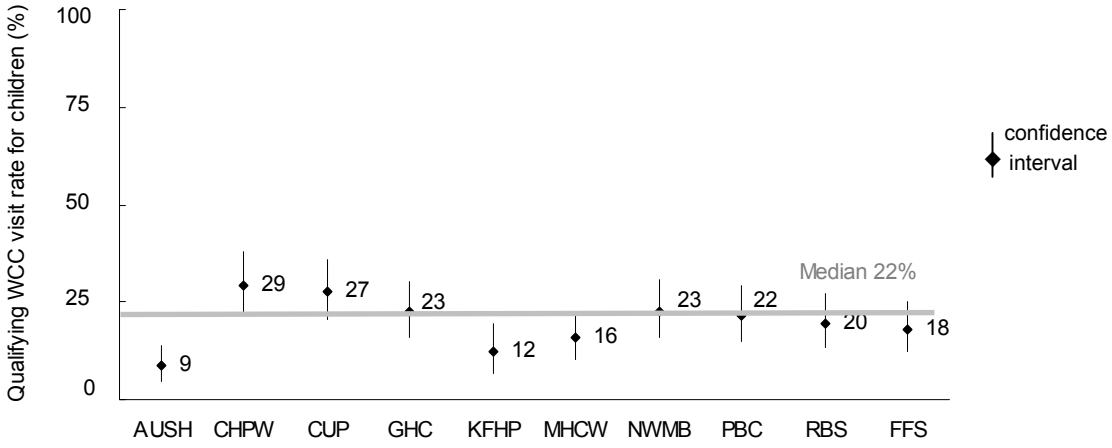


Figure 6. MCO and FFS qualifying WCC visit rates for children



Performance rates for adolescent WCC visits

Adolescents are expected to have one WCC visit every other year. Adolescents' records were thus reviewed for the period from January 1, 1999 through December 31, 2000. The denominator—the expected number of visits—equals the number of adolescents in each sample.

Figure 7. Reported WCC visit rates for adolescents

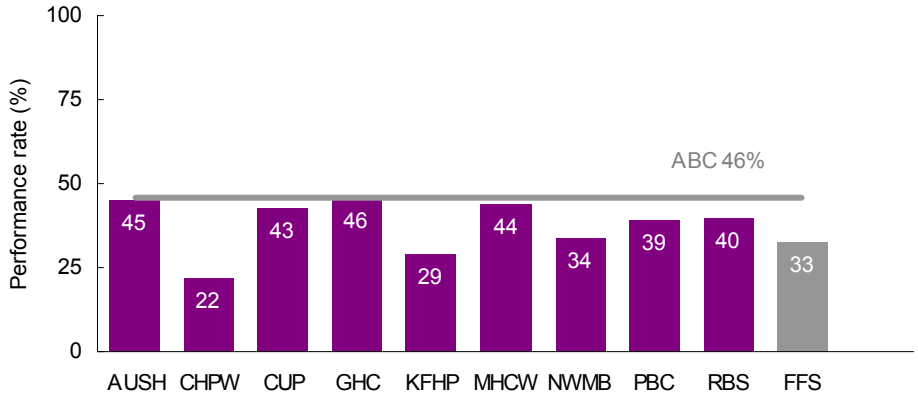


Figure 8. Qualifying WCC visit rates for adolescents

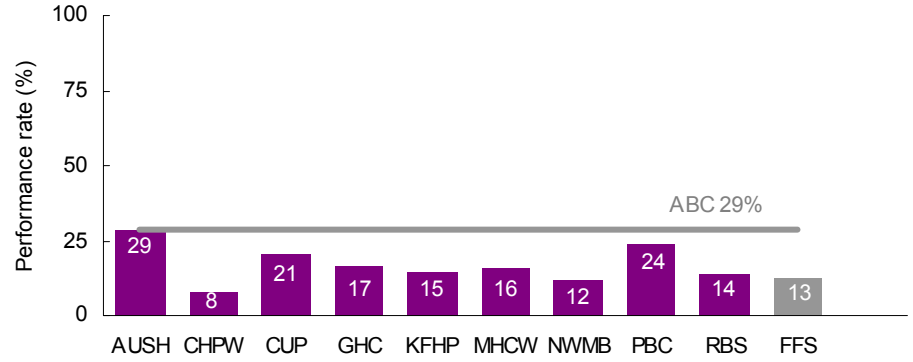
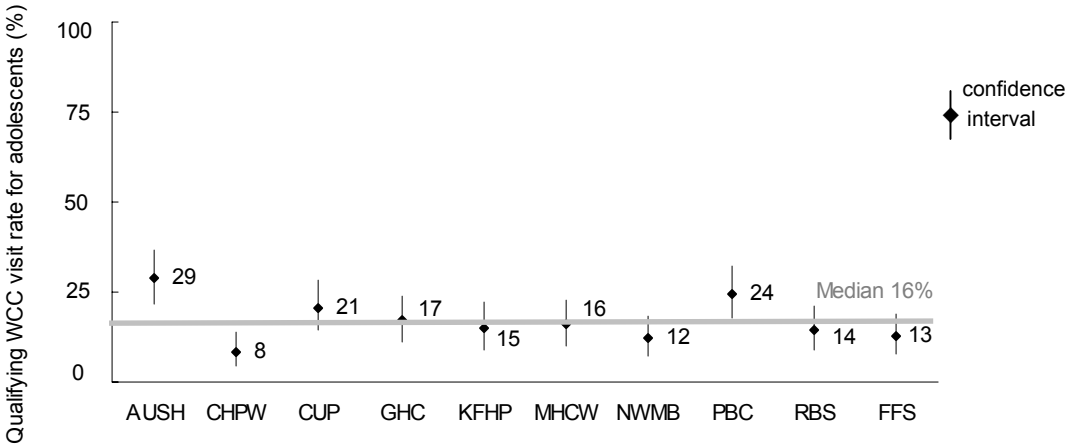


Figure 9. MCO and FFS qualifying WCC visit rates for adolescents



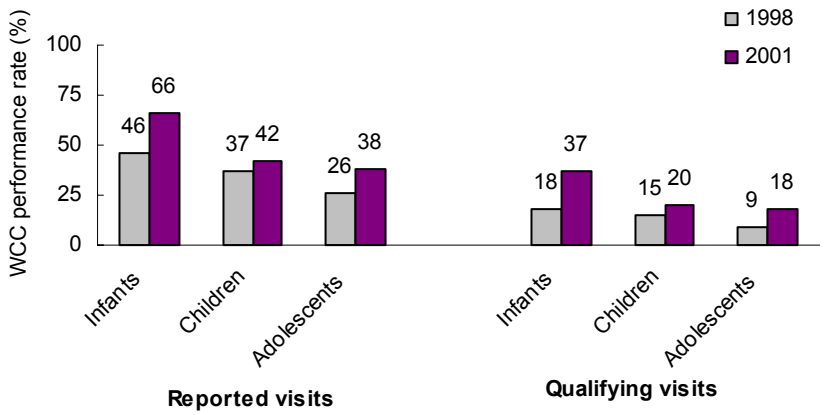
Required clinical areas

All four clinical areas—health history and physical exam, developmental assessment, mental health assessment, and health education/anticipatory guidance—must be completed during a WCC visit, and a minimum number of elements must be addressed for the visit to be considered a *qualifying* WCC visit. This review indicated that at least 98 percent of the time, providers sufficiently documented one clinical area for all age groups; and at least 87 percent of the time, they documented two. Documentation for three areas drops to 82 percent for infants, 80 percent for children, and 66 percent for adolescents. For all four areas, documentation drops to 56 percent for infants, 48 percent for children, and 46 percent for adolescents. The two clinical areas most likely to be missed across all age groups are mental health and anticipatory guidance.

Statewide aggregate results for MCOs

Figure 10 compares statewide, aggregate MCO performance rates for reported and qualifying WCC visits in 1998 with those from 2001 and compares rates among age groups.

Figure 10. Statewide, aggregate performance rates for reported and qualifying WCC visits[8]



Structured examination forms

In 1998, MAA began encouraging providers to use a structured WCC form to document WCC visits and also began assessing the use of these forms.

Figure 11 shows the correlation between the use of structured WCC forms and the qualifying visit rate. The correlation has remained constant since 1998.

[8] When comparing performance rates for adolescent WCC visits, note that records were reviewed for a one-year period in 1998 and for a two-year period in 2001.

Figure 11. Effect of using structured WCC forms on qualifying visit rate in 2001

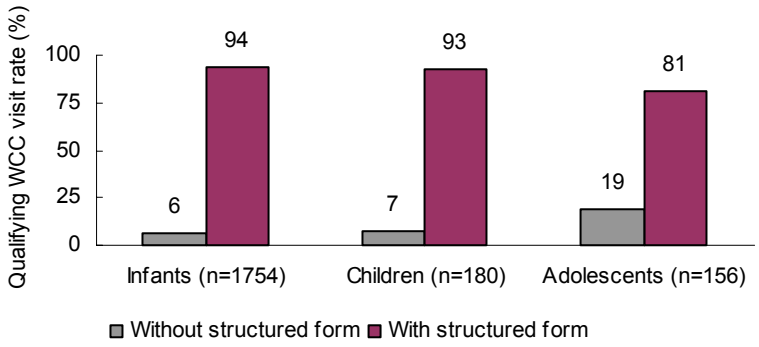
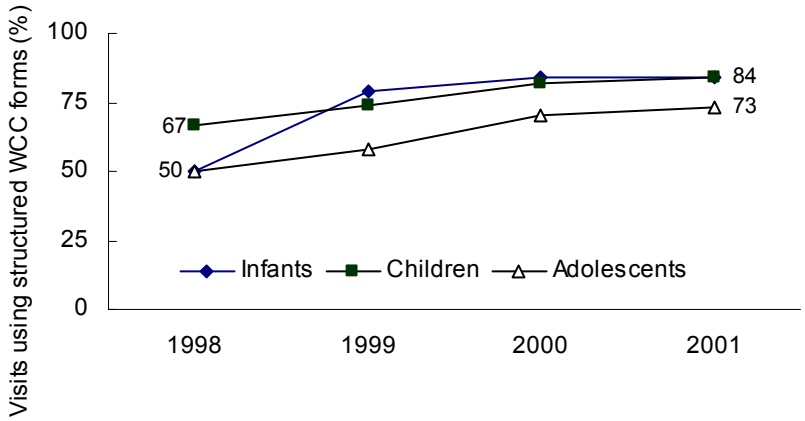


Figure 12 illustrates the growth in use of structured WCC examination forms since MAA stepped up efforts to encourage their use. Use of structured forms for infant visits increased from 50 percent to 84 percent; for child visits, from 67 percent to 82 percent; and for adolescent visits, from 50 to 70 percent.

Figure 12. Growth in use of structured WCC examination forms, 1998–2001

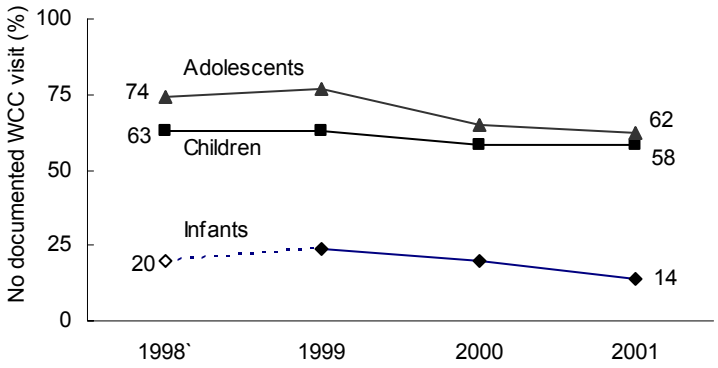


Rates for no documented WCC visit

The number of individuals with no documented WCC visit has steadily declined since 1998. However a large gap remains between the relatively low rate of undocumented WCC visits for infants and the much higher rate for children and adolescents. Figure 13 shows year-to-year comparisons of the percentage of clients who had no documented WCC visit.

Undocumented visits reflect individuals who had no visit within the review period and those whose records could not be located or otherwise were not available for review. (NOTE: The methodology used to calculate rates for infants was different in 1998. Therefore, that datum point represents a conservative estimate only.)

Figure 13. State aggregate rates for children with no documented WCC visit, 1998-2001.



Encounter visits and follow-up care

Encounter visits—visits other than WCC visits—and follow-up care can be an indicator of healthcare accessibility and quality. Follow-up care is often appropriate after an encounter visit or a WCC visit if a medical problem is identified. The medical records indicate that infants averaged five encounter visits in 2000; children and adolescents averaged three.

In all three age groups, for individuals whose medical record showed evidence of a medical problem, appropriate follow-up care was documented nearly 100 percent of the time. In addition to providing necessary healthcare, encounter visits and follow-up care present an opportunity to schedule WCC visits for individuals who need them.

"We have what we call a 'trickle down the hall' policy. If we see 'Johnny Jones' walking down the hall with an ear infection, and we know he needs a well-child checkup, we either do it then, or we use that visit to schedule another appointment right away."

Sandra Paxson, Director
Columbia Public Health Clinic
(a Washington State benchmark clinic)

Discussion

The percentage of reported and qualifying visits for all three age groups—infants, children, and adolescents—has increased since 1998, when MAA stepped up its quality improvement efforts by

- encouraging the use of structured examination forms
- requiring MCOs to develop action plans to address qualifying WCC visit rates below 60 percent
- encouraging MCOs to develop their own internal quality improvement efforts

Although reported WCC rates have increased in the past four years, particularly for infants, one-third of the infants and more than one-half of the children and adolescents do not have documentation of a WCC visit. This suggests a significant opportunity for intensifying outreach strategies for scheduling WCC visits.

Qualifying WCC visit rates indicate the completeness of the WCC visits according to EPSDT requirements. Rates of qualifying visits have also increased—from approximately one-third of reported visits in 1998 to one-half of reported visits in 2001. Still, significant opportunity remains for developing interventions that help providers ensure that every *reported* visit is a *qualifying* visit.

MCO performance rates generally exceed FFS performance rates in all age groups, with few exceptions. However, services provided on a FFS basis pose challenges to obtaining high performance rates. FFS clients are not required to have a health plan "medical home" or an assigned primary care provider, situations that inhibit the ability to establish good client-practitioner communication. Because no single provider is responsible for healthcare, it is often difficult to identify the provider most likely to have delivered preventive care. In addition, some clients in the sample had no claims in the data file or had claims for ancillary services only; thus, if preventive care was delivered, the provider for medical record review could not be identified.

Clinic-specific feedback

The ABC performance feedback packets were provided to individual clinics so they could assess their own performance rates against the top performances of their peers. Clinics found the packets useful: some requested a presentation of the report at their monthly staff meetings; others requested more information. The clinics expressed interest in improving their rates when they were low, and took the opportunity to learn where they had fallen short. Clinic staff provided the following insights:

- Some providers had not understood the EPSDT requirements for a qualifying WCC visit. For example, they did not know that all four clinical areas must be completed for a visit to be counted as a qualifying one.
- Many providers did not know that the two clinical areas most often missed for all three age groups were mental health and health education/anticipatory guidance. They wanted to know what constituted "mental health assessment" in infants. They did not realize, for example, that they could meet this requirement by simply documenting that they had inquired about family dynamics or that they discussed the emotional well-being of the caretaker.
- Some clinics did not use a structured well-child examination form; others used forms that were incomplete. Previous results have demonstrated that use of standardized forms

dramatically increases the rate of qualifying visits.

- Some providers addressed elements within the required clinical areas, but failed to document them in the medical record.
- Opportunities to schedule or perform a well-child examination when the child was in the office for another reason were missed.
- Mandatory school sports physicals are good opportunities to conduct complete WCC examinations for adolescents.
- Automated systems that alert staff when WCC visits are due help to increase reported visit rates.

Structured WCC examination forms

Using structured WCC examination forms helps increase the rate of qualifying visits. In the fall of 2001, MAA published a standardized examination form that reflects age-appropriate EPSDT requirements, and made it available free to all Washington providers serving Medicaid clients. These forms, coupled with clear explanations of what constitutes meeting EPSDT requirements, represent a promising strategy for improving qualifying WCC rates.[9]

Model for Improvement

- *What do you want to do?*
- *How do you know a change is improvement?*
- *What changes will result in improvement?*

Continuous improvement results from a series of improvement cycles.

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[9] For more information about the forms, providers may contact Margaret Wilson, RN, MN, at MAA, 360-725-1658.

Conclusions

- Quality improvement efforts have had a positive effect on WCC performance rates for all age groups.
- Rates for both reported and qualifying WCC visits continue to increase, but the increase is much smaller for children and adolescents than it is for infants, and considerable opportunities remain for improvement in all age groups.
- Provider understanding of the EPSDT requirements is crucial to increasing qualifying WCC visit rates
- Clinics and providers welcome examples of structured WCC examination forms, using them "as is" or adapting existing forms.
- Benchmarking, especially when it presents achievable goals, shows promise as a successful intervention strategy for encouraging improvement.

Recommendations

Get them in

- Use doctor visits for any medical event as an opportunity to conduct or schedule a WCC examination, if one is due. The data indicate that most children of all ages visit the doctor at least three times a year for reasons other than a WCC visit. If the child has not had a WCC examination, any visit could be used to perform a WCC examination or schedule one.
- Use sports examinations for adolescents as opportunities to do complete WCC examinations.
- Use follow-up calls to schedule WCC visits if a visit is due.
- Encourage the use of a reminder system that notifies schedulers when a child is due for a WCC visit.
- Investigate barriers parents or caregivers face in scheduling WCC visits—possibly by conducting surveys or focus groups—and develop ways to address these barriers.

Make it count

- Make sure providers understand what constitutes a qualifying WCC visit—that all required elements in all four of the following clinical areas must be addressed and documented:
  - Health history and physical examination
  - Developmental assessment
  - Mental health assessment
  - Health education and anticipatory guidance
- Make sure providers understand what constitutes addressing the required elements within the clinical areas, and what those requirements mean for each age group. For example, clarify that an assessment of mental health in an infant could mean making notes on family characteristics or circumstances that could affect the child's mental health.
- Use structured WCC examination forms that include age-appropriate EPSDT requirements.